MEDICAID

A BRIEF SUMMARY OF
TITLE XIX
OF THE SOCIAL SECURITY ACT

February, 1992

Health Care Financing Administration

NOTE:
This summary is an attempt at a brief, simple version of a very complex subject. It should be used only as a general guide and an interim overview of the Medicaid Program.

THE MEDICAID PROGRAM: A BRIEF SUMMARY
as of October, 1991

Program Overview

Title XIX of the Social Security Act is a matching entitlement program which provides medical assistance for certain individuals and families with low incomes and resources. The program, known as Medicaid, became law in 1965 as a jointly funded cooperative venture between the Federal and State governments to assist States in the provision of more adequate medical care to eligible needy persons. Medicaid is the largest program providing medical and health-related services to America's poor people.

Within broad national guidelines which the Federal government provides, each of the States: (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Thus, the Medicaid program varies considerably from State to State, as well as within each State over time.

In 1990, the Medicaid program provided medical services to over 25 million eligible poor persons who were aged, blind, disabled, pregnant, or in certain families with children. Federal and State combined payments to medical vendors for Medicaid services were reported by the States as being $64.86 billion for 1990, while total expenditures for the Medicaid program were $68.7 billion ($38.9 billion Federal and $29.8 billion State monies), plus administrative costs.

Maintenance Assistance Status and Basis of Eligibility

States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for Federal funds, States are required to provide Medicaid coverage for most individuals who receive Federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. These are the mandatory Medicaid eligibility groups:

- Recipients of Aid to Families with Dependent Children (AFDC);
- Supplemental Security Income (SSI) recipients (or aged, blind and disabled individuals in States that apply more restrictive eligibility requirements);
- Infants born to a Medicaid-eligible pregnant woman. Medicaid eligibility must continue throughout the first year of life so long as the infant remains in the woman's household and she remains eligible, or would be eligible if she were still pregnant;
- Recipients of adoption assistance & foster care under Title IV-E of the Social Security Act;
- Children under age 6 and pregnant women who meet the State's AFDC financial requirements or whose family income is at or below 133 percent of the Federal poverty level. (Effective July 1, 1991, States are required to extend Medicaid eligibility until age 19 to all children born after September 30, 1983 in families with incomes at or below the Federal poverty level. This phases in coverage, so that by the year 2002, all poor children under age 19 will be covered);
- Certain Medicare beneficiaries (described later); and
- Special protected groups (These are usually individuals who lose cash assistance because of the cash program's rules, but who may keep Medicaid for a period of time. Examples are persons who lose AFDC or SSI payments due to earnings from work or increased Social Security benefits. Two-parent, unemployed families whose cash AFDC assistance is limited by the State are protected and are provided a full 12 months of Medicaid coverage).

States also have the option to provide Medicaid coverage for other "categorically needy" groups. These optional groups share characteristics of the mandatory groups, but the eligibility criteria are somewhat more

liberally defined. The broadest optional groups that States may cover (and for which they will receive Federal matching funds) under the Medicaid program include:

- Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is below 185% of the Federal poverty level (the percentage to be set by each State);
- Certain aged, blind or disabled adults who have incomes above those requiring mandatory coverage, but below the Federal poverty level;
- Children under age 21 who meet income and resources requirements for AFDC, but who otherwise are not eligible for AFDC;
- Institutionalized individuals with income and resources below specified limits;
- Persons receiving care under home and community-based waivers;
- Recipients of State supplementary payments; and
- "Medically needy" persons (described below).

The option to have a "medically needy" program allows States to extend Medicaid eligibility to additional qualified persons who have too much income to qualify under the mandatory or optional categorically needy levels. This option allows them to "spend down" to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their excess income, thereby reducing it to a level below the maximum allowed by that State's Medicaid plan. States may also allow families to establish eligibility for medically needy coverage by paying monthly premiums to the State in an amount equal to the difference between family income (reduced by unpaid expenses, if any, incurred for medical care in previous months) and the threshold allowance for income eligibility.

The "medically needy" Medicaid program does not have to be as extensive as the categorically needy program. However, if a State does elect to have a medically needy program, it is required to provide coverage to certain children under age 18 and pregnant women. It may choose to provide coverage to other medically needy persons: aged, blind, and/or disabled persons; caretaker relatives of children deprived of parental support and care; and certain other financially eligible children up to age 21. During 1990, thirty eight States provided Medicaid to at least some groups under a medically needy program.

Amplification on Medicaid Eligibility

Once entitlement to Medicaid is determined, coverage generally is retroactive to the third month prior to application. Coverage generally stops at the end of the month in which a person's circumstances change. Most States have additional "State-only" programs to provide medical assistance for specified poor persons who do not qualify for the Medicaid program. No Federal funds are provided for State-only programs.

Medicaid does not provide medical assistance for all poor persons. Even under the broadest provisions of the Federal statute (except for emergency services for certain persons) the Medicaid program does not provide health care services, even for very poor persons, unless they are in one of the groups designated above. Low income is only one test for Medicaid eligibility; assets and resources are also tested against established thresholds. As noted earlier, categorically needy persons who are eligible for Medicaid may or may not also receive cash assistance from the AFDC program or from the SSI program, and medically needy persons who would be categorically eligible except for income or assets may become eligible for Medicaid solely because of excessive medical expenses.

Significant changes were made in the Medicare Catastrophic Coverage Act (MCCA) of 1988 which impacted Medicaid. Although much of the MCCA was repealed, the portions impacting Medicaid remain in effect. Recent changes in the law also have accelerated Medicaid eligibility for some nursing home patients by protecting more income and assets for the institutionalized person's spouse at home. Before an institutionalized

person's monthly income is used to pay for the cost of institutional care, a minimum monthly maintenance needs allowance is deducted for bringing the income of the community spouse up to a moderate level (within the available income).

For certain poor Medicare recipients known as "qualified Medicare beneficiaries" or "QMBs" (those beneficiaries with incomes below the Federal poverty level and with resources at or below twice the standard allowed under the SSI program), the Medicaid program in most States pays the Medicare premiums, deductibles and certain coinsurance costs, if the recipient applies for this help. These new QMBs are not quite poor enough to qualify for Medicaid and usually are not eligible for Medicaid services; they benefit because their Medicare cost-sharing expenses are paid by the State Medicaid programs.

Scope of Medicaid Services

Title XIX of the Social Security Act requires that, in order to receive Federal matching funds, certain basic services must be offered in any State program:

- inpatient hospital services;
- outpatient hospital services;
- prenatal care;
- physician services;
- nursing facility (NF) services for individuals aged 21 or older;
- home health care for persons eligible for skilled-nursing services;
- family planning services and supplies;
- rural health clinic services;
- laboratory and x-ray services;
- pediatric and family nurse practitioners service;
- certain Federally-qualified ambulatory and health-center services;
- nurse-midwife services; and
- early and periodic screening, diagnosis, and treatment (EPSDT) services for children under age 21.

States may also receive Federal assistance for funding if they elect to provide other optional services (currently 32 options). The most commonly covered optional services under the Medicaid program include:

- clinic services;
- nursing facility services for the aged and disabled;
- nursing facility care for the mentally retarded (ICFs/MR);
- optometrist services and eyeglasses;
- prescribed drugs;
- prosthetic devices; and
- dental services.

A new optional service now allows States to provide home and community-based care to certain individuals who are either medically needy or eligible for Medicaid due to receipt of SSI benefits: those who have limitations in specified activities of daily living (toileting, transferring, and eating), and are at least 65 years of age. The services to be provided to these persons may include personal care services, chore services, respite care services, adult day care, homemaker/home health aide, and nursing services. Another option allows up to eight States to elect to establish and provide community-supported living arrangement services for individuals with mental retardation or a related condition.

Amount and Duration of Medicaid Services

Within broad Federal guidelines, States determine the amount and duration of services offered under their Medicaid programs. They may limit, for example, the days of hospital care or the number of physician visits covered. States are prohibited from limiting the duration of coverage for medically necessary inpatient hospital services provided to Medicaid-eligible children under age 6 in disproportionate share hospitals and to infants in all hospitals.

With certain exceptions, a State's Medicaid plan must allow recipients freedom of choice among participating providers of health care. States may provide and pay for Medicaid services through various pre-payment arrangements, such as a health maintenance organization (HMO). In general, States are required to provide comparable services to all categorically needy eligible persons. There are two important exceptions:

. Health care services identified under the Federal EPSDT program as "medically necessary" for eligible children must be provided by Medicaid, even if those services are not included as part of the covered services in that State's plan; and

. States may request home and community-based services "waivers" under which they offer an alternative health care package for persons who would otherwise be institutionalized under Medicaid. States are not limited in the scope of services they can provide under such waivers so long as they are cost effective (except that, other than as a part of respite care, they may not provide room and board for such recipients).

The amount and duration of services provided by each Medicaid program is described in each State plan. However, revisions in Federal laws and regulations (as well as various State budgetary limitations) impact the plans, producing changes in amount, duration and scope of Medicaid services within each State plan.

Payment for Medicaid Services

Medicaid operates as a vendor payment program, with payments made directly to the providers. Providers participating in Medicaid must accept the Medicaid reimbursement level as payment in full. Each State has broad discretion in determining (within Federally-imposed upper limits and specific restrictions) the reimbursement methodology and resulting rate for services, with two exceptions: 1) for institutional services, payment may not exceed amounts that would be paid under Medicare payment rates; and 2) for hospice care services, they must pay no lower than Medicare rates.

States may impose nominal deductibles, coinsurance or co-payments on some Medicaid recipients for certain services. Emergency services and family planning services must be exempt from such co-payments. Certain Medicaid recipients must be excluded from this cost sharing: pregnant women, children under age 18, hospital or nursing home patients who are expected to contribute most of their income to institutional care, and categorically needy HMO enrollees.

The amount of total Federal outlays for Medicaid has no set limit (cap); rather, the Federal government must match whatever the individual State decides to provide, within the law, for its eligible recipients. However, reimbursement rates must be sufficient to enlist enough providers so that Medicaid care and services are available under the plan at least to the extent that such care and services are available to the general population in that geographic area. Also, States must augment payment to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid recipients and/or other low-income persons.

The portion of the Medicaid program which is paid by the Federal government, known as the Federal Medical Assistance Percentage (FMAP), is determined annually for each State by a formula that compares the State's average per capita income level with the national average. By law, the FMAP cannot be lower than 50 percent or more than 83 percent. The wealthier States have a smaller share of their costs reimbursed. In 1991, the FMAPs varied from 50 percent (paid to 12 States and D.C.) to 79.93 percent (to Mississippi), with the average Federal share among all States being 57 percent for Medicaid service expenditures. The Federal government also shares in the State's expenditures for administration of the Medicaid program. Most administrative costs are matched at 50 percent for all States. However, depending on the complexities and need for incentives for a particular service, higher matching rates (75, 90 and 100 %) are authorized for certain functions and activities.

Medicaid - Medicare Relationship

Some aged and/or disabled person are covered under both Medicaid and Medicare (Title XVIII of the Social Security Act). These recipients are known as "dual beneficiaries" or "dual eligibles". The Medicare program provides Hospital Insurance (HI, also known as Part A) and Supplementary Medical Insurance (SMI, also known as Part B). For those persons aged 65 or older (and for certain disabled persons) who have insured status under Social Security, coverage for Medicare HI is automatic.

Coverage for SMI, however, requires payment of a monthly premium. For the dual-eligible persons, the State Medicaid programs pay the premiums, deductibles and certain coinsurance Medicare costs. For the dual-eligible recipients, Medicaid supplements the Medicare coverage, and provides many health care services that are not provided under Medicare. Services such as eyeglasses, hearing aids, and nursing care beyond the 100 day limit provided by Medicare may be included, as each State elects.

Disabled persons who lost Medicare benefits because of their return to work are now allowed to purchase Medicare HI and SMI coverage. For those disabled working persons with income below 200 percent of the Federal Poverty level, the State Medicaid programs must pay the HI premium. The State Medicaid programs are not required to pay SMI premiums for these recipients.

Medicaid Trends and Statistical Summary

The following displays, summarized from data provided annually by the States, show the distributions of the 25 million Medicaid recipients and of the amounts paid for the almost $65 billion in services they received in 1990. These payments are only for direct provision of health care. They do not include Medicaid payments for the premiums for Medicare, HMOs or others; nor do they include administrative costs.

Numbers of Medicaid recipients and vendor payments by categories of people:

Categories of People	Total Payments
. 11,219,969 were dependent children under age 21	@ $ 9,100,096,000;
. 6,010,407 were AFDC adults or pregnant women	@ $ 8,589,738,000;
. 3,634,678 were permanently & totally disabled	@ $23,969,413,000;
. 3,202,129 were aged 65 or older	@ $21,508,078,000;
. 989,543 were other Title XIX recipients	@ $ 1,050,654,000;
. 83,315 were blind	@ $ 434,233,000.

Numbers of Medicaid recipients and vendor payments by type of services:
(Recipients often use more than one service, so may be counted more than once)

Types of Service	Total Payments
. 4,685,553 received inpatient hospital services	@ $18,387,780,000;
. 1,461,317 received other nursing facility care	@ $17,693,483,000;
. 146,931 received ICFs/MR services	@ $ 7,353,596,000;
. 17,294,416 received prescription drug services	@ $ 4,420,216,000;
. 17,078,446 received physician services	@ $ 4,018,144,000;
. 719,194 received home health services	@ $ 3,403,955,000;
. 12,370,205 received outpatient hosp. services	@ $ 3,324,319,000;
. 5,126,540 received other or unidentified care	@ $ 2,385,665,000;
. 2,803,971 received clinic services	@ $ 1,687,988,000;
. 8,959,413 received lab and x-ray services	@ $ 721,163,000;
. 4,552,049 received dental services	@ $ 497,855,000;
. 3,872,823 received other practitioner services	@ $ 372,423,000;
. 1,751,618 received family planning services	@ $ 264,869,000;
. 2,951,633 received EPSDT services	@ $ 197,919,000;
. 223,613 received rural health clinic care	@ $ 34,410,000.

Medicaid was initially formulated as a medical care extension of Federally funded income maintenance programs for the poor, with an emphasis on dependent children and their mothers. Over time, however, Medicaid has been diverging from a firm tie to eligibility for cash programs. Recent legislation assures Medicaid coverage to an expanded number of low-income pregnant women, poor children, and some Medicare beneficiaries who are not eligible for any cash assistance program, and who would not have been eligible for Medicaid under the earlier Medicaid rules. Changes also focus on enhanced outreach toward specific pregnant women and children, increased access, continuation of specific benefits, restrictions on limits of service, and quality of care.

In addition to the increase in numbers of beneficiaries from new legislation, the most pronounced Medicaid trend in recent years has been the continued sharp increase in expenditures for intensive acute care, for nursing facility care for the mentally retarded and disabled, and for home health and nursing facility services for the aged and disabled. In 1990, the various types of long term care services for the elderly, disabled and mentally retarded required forty-three percent of all Medicaid payments. The percent of total Medicaid funds spent for home health care is now four times as much as ten years ago. Intensive care for very premature babies or others with very serious problems can cost $3,000 per day per baby now. A few other persons who have complex and extensive health care needs on a continuing basis cost the Medicaid program over $200,000 per person per year for many years. The average Medicaid payment for ICF/MR care was over $50,000 per recipient in 1990. By comparison, 1990 Medicaid vendor payments for the total health care services for AFDC children under age 21 averaged only $811 per child.

Federal outlays for the Medicaid program have increased from $2.5 billion in fiscal year (FY) 1970 to $38.9 billion in FY 1990. Under current law, the projected growth of Federal Medicaid expenditures is expected to be 25% just for FY 1991. The compound rate increase between FY 1990 and FY 1995 is now projected to average over 17% per year (or a doubling in about four years). Thus, if the current program and expenditure trends continue and there are no significant changes to the Medicaid program, payments for the total Federal and State Medicaid program for 1996 are projected to be near $180 billion, and may well exceed $300 billion by the year 2000.

Conclusion

Medicaid policies for eligibility and services are complex, and vary considerably even among similar-sized and/or adjacent States. A person who is eligible in one State might not be eligible if in another State. Services provided by one State may differ considerably in amount, duration or scope from services provided in a similar State. Increase in expenditures for the total Medicaid program over the years have exceeded the increase in numbers of persons or services provided. That is, the cost per Medicaid recipient has increased annually. This seems due, primarily, to:

- the accelerated rate of inflation for medical and health-related services when compared to general inflation;
- the results of technological advances to keep more very low birth-weight babies and other critically ill or severely injured persons alive, but in need of continuing very expensive care;
- the increase in rates of reimbursement to the health care providers;
- the addition of new requirements to the Medicaid program; and
- the increase in numbers of very old and disabled persons requiring extensive acute and/or long term health care and related services.

The U.S. Congress, the Department of Health and Human Services and the individual States continually seek to make improvements in Medicaid's quality, effectiveness and extent of health care services. But the Medicaid programs must function within the Federal and State constraints of budgetary limitations as well as other economic, social, and political factors. Thus, with frequent revisions in Federal laws, in HCFA regulations, and in individual State plans, the Medicaid program is continually changing.

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Mary Onnis Waid, Senior Research Analyst, Health Care Financing Administration.
Address: J-1 EQ05, 6325 Security Blvd. Baltimore, MD 21207. Telephone: (410) 966-7921.

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For a more thorough (500+ pages) explanation of Medicaid, see: Medicaid Source Book: Background Data and Analysis, 1988, from The Congressional Research Service, Library of Congress, in Washington, D.C.

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